STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/8/16 through 11/10/16. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 169 certified bed facility was 149 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Residents 1 through 6 and Residents 12 through 14) and 5 closed record reviews (Residents 8 through 11 and Resident 15).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(b)(11) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		12/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician when medications were not available for administration for one of 15 residents in the surveys sample, Resident #5. The facility staff failed to notify the physician when two medications were not available for administration for Resident #5. The findings include: Resident #5 was admitted to the facility on 11/7/16 with diagnoses that included but were not limited to: high blood pressure, elevated cholesterol levels in the blood, muscle weakness, stroke, fracture of lower leg, diabetes and history of breast cancer. There was no completed MDS (minimum data set) assessment as the resident was just admitted on the day prior to the start of the survey. The nursing admission assessment, dated, 11/7/16 at 4:10 p.m. documented the	F 157	F157 1. The attending physician and RP of Resident #5 were notified of the missed dose of medications due to medication unavailability 2. All residents with missed doses of medication due to unavailability could be affected by this deficient practice. 3. Licensed staff will be educated by the Staff Development Coordinator or designee on the facility policy on Physician Notification. 4. The Unit Managers will conduct audits of medication availability and administration notification five times weekly for four weeks, then randomly weekly for eight weeks. Reports of audits will be reported to the QA committee for review and revision as needed monthly for 3 months. 5. Date of compliance: December 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

resident was alert and oriented to person and place, but not time. The resident was documented as appearing anxious. A brace was noted on the right leg.

The physician orders dated 11/7/16, documented, "Livalo Tablet (used to treat high cholesterol (1)) 1 MG (milligram); Give 1 tablet by mouth at bedtime for high cholesterol. Ranolazine ER (extended release) Tablet (used to treat angina - chest pain (2)) 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health."

The MAR (medication administration record) for November 2016 documented, "Livalo Tablet 1 MG; Give 1 tablet by mouth at bedtime for high cholesterol." On 11/7/16 at 9:00 p.m. a "19" was documented in the box for administration. The code for indicated "19" documented, "See nurse's note."

The nurse's note dated 11/7/16 at 9:56 p.m. documented, "Pending deliver (sic) from Rx (pharmacy)." This note was written by LPN (licensed practical nurse) #7.

The November 2016 MAR documented, "Ranolazine ER Tablet 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health." The dose for 9:00 p.m. on 11/7/16 was documented as having been given.

The manifest from the pharmacy dated, 11/8/16 at 2:11 a.m. documented Resident #5's medications were delivered at 2:11 a.m. on 11/8/16.

Review of the STAT (Immediate emergency box) failed to evidence the Livalo or Ranolazine ER in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

the box.

An interview was conducted with LPN (licensed practical nurse) #6 on 11/9/16 at 10:42 a.m., regarding the process staff follows when a medication is not available on the medication cart at the prescribed time of administration. LPN #6 stated, "First you check the STAT box and if it's not a medication that is in there, you call the pharmacy and find out what time it will be delivered. You have to notify the doctor and RP (responsible party) when a medication is not available to administer. The doctor may give you an order to hold that one dose."

An interview was conducted with LPN #7 on 11/9/16 at 2:35 p.m., regarding the process staff follows when a medication is not available for administration at the prescribed time. LPN #7 stated, "First you call the pharmacy and find out where it (the medication) is. You can pull it from the STAT box if it's available in the box." LPN #7 was asked if staff call the pharmacy at 9:00 p.m. at night. LPN #7 stated, "No, you can call the doctor to get a one-time order to hold the medication." When asked if she called the doctor when the Livalo was not available on 11/7/16 at 9:00 p.m., LPN #7 stated, "No I didn't call anyone." LPN #7 was asked how she administered the Ranolazine to Resident #5 on 11/7/16 at 9:00 p.m., as Resident #5's medications were not delivered to the facility until 2:11 a.m. on 11/8/16 and the medication was not in the STAT box, yet she had documented the medication as having been administered, LPN #7 stated, "That's a documentation issue, I did not give it." When asked if she called anyone, LPN #7 stated, "No, I didn't."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4	F 157		

The facility policy, "Medication Shortages/Unavailable Medications" documented in part, 3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply (STAT box). 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2. Use of an emergency (back up) Third Party Pharmacy. 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.
ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 5 No further information was provided prior to exit. (1) Livalo (Pitavastatin) is used together with diet, weight-loss, and exercise to reduce the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol ('bad cholesterol') in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol ('good cholesterol'). Pitavastatin is in a class of medications called HMG-CoA reductase inhibitors (statins). It works by slowing the production of cholesterol in the body to decrease the amount of cholesterol that may build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a610018.html (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011950/?report=details	F 157		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for one of 15 residents in the survey sample, Resident # 3. The facility staff failed to develop a comprehensive care plan for the triggered care area of behavior on Resident # 3's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 8/30/16. The findings include: Resident # 3 was admitted to the facility on 11/1/13 with diagnoses that included but were not limited to: low iron, pain, dementia (1), hypertension (2), dysphagia (3), and edema (4). Resident # 3's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 8/30/16 coded the resident as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score	F 279	F279: Development of Care Plan 1. A behavior Care Plan was developed for Resident #3 immediately. 2. Residents who have behaviors have the potential to be affected by this deficient practice. Residents with behaviors care plans have been reviewed for accuracy. 3. The Social service department was educated by the MDS Coordinator on the policy and procedure for developing behavior care plans related to the triggered care area of behavior. 4. The MDS Coordinator or designee will conduct weekly audits of resident care plans for four weeks, then randomly for 8 weeks to assure updates are made. Audits will be reviewed and reported in QA for three months for review and revision as needed. 5. Date of compliance: December 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7	F 279		

of 0 - 15, 3 (three) being severely impaired cognition for daily decision making. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed "09. Behavioral Symptoms" was coded as "Addressed in Care Plan."

Review of Resident # 3's comprehensive care plan with a revision date of 9/02/2016 failed to evidence a care plan to address Resident # 3's behaviors.

On 11/9/16 at 11:30 a.m., an interview was conducted with OSM (other staff member) # 5, social worker regarding a care plan for Resident # 3's behaviors. OSM # 5 reviewed the annual MDS assessment with an ARD of 8/30/16 for Resident # 3 and the comprehensive care plan with a revision date of 9/02/2016. When asked who was responsible for completing a behavior care plan for Resident # 3 OSM # 5 stated that she was. When asked about the missing behavior care plan for Resident # 3, OSM # 5 stated "I just created one today."

On 11/9/16 at 11:35 OSM # 5 provided this surveyor with a copy of a care plan for Resident # 3. The Care plan dated "11/09/2016" documented, "Focus: Resident has displayed the following behaviors: hx (history) of refusing/resisting care & (and) combative with staff. Date Initiated: 11/09/2016."

The facility's policy "Care Plan" documented, "An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8 an as needed basis." On 11/39/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 3, the regional nurse, were made aware of the findings. No further information was provided prior to exit. Reference: (1) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.20(d)(3), 483.10(k)(2) The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to review and revise the comprehensive care plan for one 15 residents in the survey sample, Resident #2. The facility staff failed to review and revise Resident #2's care plan when her BIMS, brief interview for mental status went from a three on 7/23/16 indicating the resident was severely cognitively impaired to a BIMS of 12 on 10/21/16 indicating the resident was cognitively intact to make daily decisions. The findings include: Resident #2 was admitted to the facility on 1/1/16 and readmitted on 7/16/16 with diagnoses that	F 280	F280 1. The Care Plan for resident #2 was updated on November 9, 2016. 2. Residents with changes in BIMS have the potential to be affected by this deficient practice. 3. The social service department was educated by the MDS Coordinator on the policy and procedure for revising and updating care plans when a change in BIMS score is noted. 4. The MDS Coordinator or designee will conduct weekly audits of resident Care Plans for four weeks, then randomly for 8 weeks to assure updates are made. Audits will be reviewed and reported in QA for three month for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 10 included but were not limited to: high blood pressure, depression, an irregular heartbeat, pressure ulcer and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/21/16 coded the resident as having scored a 12 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the significant change MDS dated 7/23/16 coded the resident as having scored a three out of 15 on the BIMS indicating the resident was severely cognitively impaired. Review of Resident #2's care plan initiated on 7/25/16 and updated on 11/9/16 documented, "Focus. Resident with impaired cognition related to dx (diagnoses) dementia. Intervention. Resident with impaired cognition as evidenced by BIMS score of three." An interview was conducted on 11/9/16 at 1:02 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked who updates the care plan, RN #2 stated, "We update it (care plan) quarterly or if there's a significant change." When asked who updated the cognitive section of the care plan, RN #2 stated, "Social work does that." When asked what policy or manual did staff use to complete the MDS, RN #2 stated, "We use the RAI (resident assessment instrument)." An interview was conducted on 11/9/16 at 1:30 p.m. with OSM (other staff member) #5, the social worker. When asked to review the BIMS on	F 280	5. Date of compliance: December 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 11	F 280		

Resident #2's 7/23/16 significant change MDS assessment and the BIMS on Resident #2's quarterly 10/21/16 MDS assessment, OSM #5 stated, "Yes, it looks like back in the summer she had a BIMS of three, that's where that care plan came from. In October her BIMS is 12." When asked why care plans are updated, OSM #5 stated, "To have an accurate plan of care to take care of the resident's needs."

An interview was conducted on 11/9/16 at 1:50 p.m. with LPN (licensed practical nurse) #10. When asked if staff interacted differently with a resident who had a BIMS of three versus a resident who had a BIMS of 12, LPN #10 stated, "Well, the resident with a BIMS of three you kinda eliminate the options. You don't want to overwhelm the resident with a BIMS of three. The resident with the higher BIMS you give more choice." When asked who used the care plan, LPN #10 stated, "Nursing." When asked why care plans were updated, LPN #10 stated, "Update them because that's your contract with the resident. It's how we care for each resident individually."

On 11/9/16 at 5:35 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 11/10/16 at 8:10 a.m. with ASM #2, the director of nursing. When asked if staff would interact differently with a resident who had a BIMS of three versus a resident who had a BIMS of 12, ASM #2 stated, "Yes. Slow things down (for the resident with a BIMS of three). Give them an opportunity to respond."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 Review of the facility's policy titled, "Care Plan" documented, "POLICY: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. PROCEDURE: F) The Comprehensive Care Plan is reviewed and updated at least every 90 days by the interdisciplinary team." No further information was obtained prior to exit.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.20(k)(3)(i) The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 15 residents in the survey sample, Resident #5 and Resident #11. 1. a. For Resident #5, the facility staff borrowed medication for administration. b. The facility staff documented a medication as administered to Resident #5, when it had not been given. 2. The facility staff failed to obtain an order for a knee brace prior to applying the brace on Resident #11.	F 281	F281: 1. The medications for resident #5 were reviewed to assure that all meds were available. Resident #11 no longer resides in facility. The nurse documenting a medication as given when it was not was disciplined. 2. Residents receiving care in facility have the potential to be affected by this deficient practice. 3. Licensed staff will be educated by the Staff Development Nurse or designee on the principles of medication administration and documentation and medication unavailable, and on entering new orders for devices. 4. The Unit Managers or designee will	12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 The findings include: 1. a. Resident #5 was admitted to the facility on 11/7/16 with diagnoses that included but were not limited to: high blood pressure, elevated cholesterol levels in the blood, muscle weakness, stroke, fracture of lower leg, diabetes, Parkinson's disease and history of breast cancer. There was no completed MDS (minimum data set) assessment as the resident was just admitted on the day prior to the start of the survey. The nursing admission assessment, dated, 11/7/16 at 4:10 p.m. documented the resident was alert and oriented to person and place, but not time. The resident was documented as appearing anxious. A brace was noted on the right leg. The physician orders dated, 11/7/16, documented, "Carbidopa-Levodopa (used to treat Parkinson's disease (1)) Tablet 25 - 100 MG (milligrams); Give 0.5 tablet (half a tablet) by mouth three times a day for Parkinson's disease for 14 days." The MAR (medication administration record) for November 2016 documented, "Carbidopa-Levodopa Tablet 25 - 100 MG; Give 0.5 tablet by mouth three times a day for Parkinson's for 14 days." The medication was documented as having been administered on 11/7/16 at 5:00 p.m. The medication was documented on 11/8/16 at 9:00 a.m. as "Medication on order from pharmacy." The manifest from the pharmacy dated, 11/8/16	F 281	conduct daily audits of MARs five times weekly for four weeks, and then randomly for eight weeks to assure that medications are given and documented appropriately. The Unit Managers or designee will review all new orders five times weekly and randomly for eight weeks to assure that all devices have current orders. The results of audits will be reported and reviewed in QA for three months for review and revision as needed. 5. Date of compliance: December 15, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 14	F 281		

at 2:11 a.m. documented Resident #5's medications were delivered at 2:11 a.m. on 11/8/16.

The STAT box contents were reviewed. It documented, "Carbidopa-Levodopa 25 - 100 tab (tablet) - contents - 8."

An interview was conducted with LPN #6 on 11/9/16 at 10:42 a.m., regarding the process staff follows when a medication is not available on the medication cart at the prescribed time of administration. LPN #6 stated, "First you check the STAT (Immediate) box and if it's not a medication that is in there, you call the pharmacy and find out what time it will be delivered. You have to notify the doctor and RP (responsible party) when a medication is not available to administer. The doctor may give you an order to hold that one dose." When asked why she didn't give the Carbidopa-Levodopa at 9:00 a.m. on 11/8/16, LPN #6 stated, "I couldn't find her medications and we are not allowed to split pills. The only ones in the STAT box were whole tablets. I finally found her medications; they had been delivered to the wrong unit. It was too close to the next dose so I notified the nurse practitioner and the family about the missed dose."

An interview was conducted with LPN #7 on 11/9/16 at 2:35 p.m., regarding the process staff follows when a medication is not available for administration at the prescribed time. LPN #7 stated, "First you call the pharmacy and find out where it (the medication) is. You can pull it from the STAT box if it's available in the box. When asked where she obtained the Carbidopa-Levodopa to administer to Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15	F 281		

on 11/7/16 at 5:00 p.m. LPN #7 stated, "Another resident was on the same medication so I borrowed it." When asked if it's acceptable to borrow medications from other residents, LPN #7 stated, "I don't know. I just did it."

The facility policy, "Medication Shortages/Unavailable Medications" documented in part, 3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply (STAT box). 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2. Use of an emergency (back up) Third Party Pharmacy. 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions."

The phrase, "Neither a borrower nor a lender be, " originated from Shakespeare's famous play, Hamlet (1603),....when it comes to medication safety, Shakespeare's advice is timeless; medications should never be borrowed from or lent to others. Cohen H, Shastay AD. Nursing2008 survey report: getting to the root of medication errors. Nursing2008 December 2008; 38(12):39-47. From the November 19, 2009 Nursing2009 issue.

The following information is provided in Fundamental of Nursing, 5th edition, Lippincott, Williams and Wilkins page 564 was used as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 16	F 281		

reference for medication administration. It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the five rights of medication administration.
1. The right medication
2. The right dose:
3. The right patient
4. The right route
5. The right time

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m. When asked which professional standard the facility utilized, ASM #3 stated, "We use our policy and procedures and Lippincott, Fundamentals of Nursing."
No further information was provided prior to exit.

(1)This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009448/?report=details

b. The facility staff documented a medication as administered to Resident #5, when it had not been given.

Resident #5's physician order dated 11/7/16, documented, "Ranolazine ER (extended release) Tablet (used to treat angina - chest pain (1)) 12 hour 500 MG (milligrams); Give 1 tablet by mouth two times a day for heart health."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 17	F 281		

The November 2016 MAR (medication administration record) documented, "Ranolazine ER Tablet 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health." The dose for 9:00 p.m. on 11/7/16 was documented as having been given.

The manifest from the pharmacy dated, 11/8/16 at 2:11 a.m. documented Resident #5's medications were delivered at 2:11 a.m. on 11/8/16.

Review of the STAT (Immediate -emergency box) failed to evidence the Ranolazine ER in the box.

An interview was conducted with LPN #7 on 11/9/16 at 2:35 p.m., regarding the process staff follows when a medication is not available for administration at the prescribed time. LPN #7 stated, "First you call the pharmacy and find out where it (the medication) is. You can pull it from the STAT box if it's available in the box." When asked if staff calls the pharmacy at 9:00 p.m. at night, LPN #7 stated, "No, you can call the doctor to get a one-time order to hold the medication." LPN #7 was asked how she administered the Ranolazine to Resident #5 on 11/7/16 at 9:00 p.m., as Resident #5's medications were not delivered to the facility until 2:11 a.m. on 11/8/16 and the medication was not in the STAT box, yet she had documented the medication as having been administered, LPN #7 stated, "That's a documentation issue, I did not give it." When asked if she called anyone, LPN #7 stated, "No, I didn't."

ASM (administrative staff member) #1, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18 administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011950/?report=details 2. The facility staff failed to obtain an order for a knee brace prior to applying the brace on Resident #11. The resident no longer resided in the facility and was assigned as Resident #11 for means of identification. Resident #11 was admitted to the facility on 10/6/16 and was discharged on 10/24/16 with diagnoses that included but were not limited to: dislocation of the right hip, diabetes, high blood pressure, elevated cholesterol and urinary tract infection. The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 10/13/16 coded the resident as having a BIMS (brief interview of mental status) of 2 indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance with all activities of	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 19	F 281		

daily living.

Review of the nurse's notes dated 10/6/16 at 3:27 p.m. documented, "Immobilizer in place to right leg this shift." Review of the nurses' notes dated from 10/7/16 to 10/24/16 documented that on 10/13/16, 10/16/16 and 10/18/16 the knee brace was in place.

Review of the physician progress notes dated 10/11/16 at 2:15 p.m. documented, "1. S/P (status post) Hip Dislocation -- KNEE BRACE IN PLACE WILL SEE WHEN PATIENT IS TO FOLLOW UP WITH ORTHO (orthopedics)."

Review of the October 2016 physician order sheet did not evidence documentation of a physician's order for the knee brace.

An interview was conducted on 11/9/16 at 12:00 p.m. with LPN (licensed practical nurse) #4. The unit manager on the unit Resident #11 resided. When asked the process staff follows if a resident has a knee brace on without a doctor's order, LPN #4 stated, "The job should have been to reach out to the primary (doctor) or ortho (orthopedic doctor) to see who ordered it and how long it could be worn." When asked if she remembered Resident #11, LPN #4 stated she did. When asked if the resident had an order for the knee brace, LPN #4 stated, "I don't have to look, no (she didn't have an order)." When asked what staff should have done LPN #4 stated that there should have been an order for the brace and instructions on the removal of the brace.

On 11/9/16 at 5:35 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 20 nurse were made aware of the findings. When asked what nursing practice standard the staff followed, ASM #3 stated, "Lippincott and our policies." An interview was conducted on 11/10/16 at 8:10 a.m. with ASM #2, the director of nursing. When asked if she remembered Resident #11 she stated she did. When asked what staff should have done regarding the knee brace, ASM #2 stated, "Her daughter brought it in. She said she always wears a brace. We have to tell family members that we can't put it on until we talk to the doctor and approves it and therapy evaluates it." Review of the facility's policy titled, "Physician's Orders" did not evidence documentation regarding obtaining an order before initiating a treatment. No further in information was provided prior to exit.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 21 Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain the highest level of well-being for one of 15 residents in the survey sample, Resident #2. The facility staff failed to obtain and monitor Resident #2's urinary output on five occasions between October 2016 and November 2016 as ordered by the physician. The findings include: Resident #2 was admitted to the facility on 1/1/16 and readmitted on 7/16/16 with diagnoses that included but were not limited to: high blood pressure, depression, an irregular heartbeat, pressure ulcer and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/21/16 coded the resident as having a 12 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the physician's November 2016 orders documented, "Record Foley Output Every Shift. every shift for monitoring. - Start Date-09/20/2016." Review of the care plan initiated on 9/20/16 and revised on 9/21/16 documented, "Focus. Resident has Indwelling Catheter. Interventions. assess and document intake and output as per facility policy." Review of the TAR (treatment administration	F 309	F309 1. The I & O order for resident #2 was discontinued. 2. Residents requiring I&O have the potential to be affected by this deficient practice. 3. The Staff Development Nurse will educate licensed staff on the documentation of I&O as ordered. 4. The Unit managers or designee will audit I&O orders for documentation five times weekly for four weeks, then randomly for eight weeks to assure that I&O orders are documented appropriately. Results of audits will be reported in the QA meeting for three months for review and revision as needed. 5. Date of compliance: December 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 22	F 309		

record) for October and November 2016 documented, "Record Foley Output Every Shift. every shift for monitoring. - Start Date-09/20/2016." Further review of the TAR for October 2016 on 10/14/16 and 10/29/16 on the evening shift and on 10/28/16 and 10/30/16 on the night shift did not evidence documentation of the resident's urinary output as the boxes were blank. Review of the TAR for November 2016 documented that on 11/5/16 on the night shift there was no evidence of documentation of the resident's urinary output.

An interview was conducted on 11/9/16 at 1:50 p.m. with LPN (licensed practical nurse) #10, the unit manager. When asked to review Resident #2's TARs for the urinary output in October 2016 and November 2016 on the dates the urinary output was not documented as noted above, LPN #10 stated they were not documented. At this time a request to interview the staff who cared for the resident on those dates was made.

An interview was conducted on 11/9/16 at 5:22 p.m. with LPN #5, the nurse who cared for the resident during October 2016 and November 2016. When asked the process staff follows to record a resident's urinary output, LPN #5 stated, "The CNA (certified nursing assistant) or nurse empty the catheter and record it in the computer. Someone forgot to give it to the nurse. The nurse can go into the CNA documentation in the computer and get the information."

An interview was conducted on 11/9/16 at 5:25 p.m. with LPN #9, the nurse who cared for the resident during October. When asked where intake and output were recorded when ordered by the physician, LPN #9 stated, "Usually goes on the MAR (medication administration record) or TAR, the output is on the TAR." The blank areas on Resident #2's October and November 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 23 TARs were reviewed with LPN #9. When asked what the blank spaces meant, LPN #9 stated, "Nobody documented there. If it's blank I would think none of us entered it." When asked how the nurse gets the urinary output to put into the computer, LPN #9 stated, "The CNA will notify us or we the nurses would go measure it." When asked if the CNAs documented output anywhere, LPN #9 stated, "I don't know anything about their documentation." Review of the CNAs October and November 2016 documentation did not evidence documentation of Resident #2's output for those dates.` An interview was conducted on 11/10/16 at 8:10 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked what it meant if the TAR was left blank for a resident's urinary output, ASM #2 stated, "It's a failure to complete their work if they don't do that." ASM #2 was made aware of the findings at that time. Review of the facility's policy titled, "INTAKE AND OUTPUT. Policy: Residents with indwelling catheters, supra-pubic catheters, urethral catheters and resident's being treated for UTI's (urinary tract infections) will have output documented. Procedure: 6. Output will be recorded for residents with foley catheters. 7. Evaluate intake and output measurement to determine adequacy. Notify the physician if not adequate and/or if output exceeds intake." No further information as provided prior to exit.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(c) Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, it was determined that the facility staff failed to treatment and services to promote healing of a pressure sore as ordered by the physician for one of 15 residents in the survey sample, Resident #2. The facility staff failed to follow the physician's order for wound care for Resident 2. The findings include: The findings include: Resident #2 was admitted to the facility on 1/1/16 and readmitted on 7/16/16 with diagnoses that included but were not limited to: high blood pressure, depression, an irregular heartbeat, pressure ulcer and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/21/16 coded the resident as having a 12 out of 15 on the BIMS indicating the	F 314	F314 1. The order for the wound care treatment change for Resident #2 was entered and MD notified of the delay in implementing new wound care order. 2. Residents with wound care orders have the potential to be affected by this deficient practice. Current residents with wound care orders were reviewed for accuracy. 3. The Staff Development Nurse or Designee will educate licensed staff on implementing new wound care orders. 4. The Unit managers or designee will audit new orders for wound care three times weekly for four weeks, then randomly for eight weeks to assure that wound care orders are implemented timely. Results of audits will be reported in the QA meeting for three months for review and revision as needed. 5. Date of compliance: December 15, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25	F 314		

resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. In Section M the resident was coded as having an un-stagable wound on the sacrum.

Review of the physician's October 2016 orders documented, "Wound care sacrum as needed for wound care. Cleanse sacrum with wound cleanser and apply santyl (1) and apply alginate (2) and apply foam dressing PRN (as needed). Order Date 11/09/2016."

Review of the TAR (treatment administration record) documented, "Wound care sacrum one time a day for wound care. Cleanse sacrum with wound cleanser and apply santyl cover with alginate and apply foam dressing Q (every) day. -Start Date- 11/10/2016."

Review of the care plan initiated on 3/24/16 and revised on 7/28/16 documented, "Focus. Impaired skin integrity - pressure ulcer at medial sacrum-. Interventions. Treatments per order."

An observation was made on 11/9/16 at 10:27 a.m. with LPN (licensed practical nurse) #10. LPN #10 cleansed the sacral wound, patted it dry and applied santyl and a foam dressing. The wound was pink (indicative of healing tissue) and without drainage. LPN #10 did not apply the alginate as ordered by the physician.

An interview was conducted on 11/9/16 at 1:50 p.m. with LPN #10. When asked what the physician ordered for Resident #11's wound care, LPN #10 stated, "I'll have to check it." On 11/9/16 at 3:25 p.m. LPN #10 stated, "So, this was a new order on November 9th. There was one dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 missed. The doctor has been notified. The RP (responsible party) was also notified." On 11/9/16 at 5:35 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." 1) Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. This information was obtained from: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d> 2) Alginate hydrogels are proving to have a wide applicability as biomaterials. They have been used as scaffolds for tissue engineering, as delivery vehicles for drugs, and as model extracellular matrices for basic biological studies. This information was obtained from: <https://www.ncbi.nlm.nih.gov/pubmed/16881042>	F 314		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.25(m)(2)	F 333		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 27 The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure two of 15 residents were free of a significant medication error, Residents #15 and #10. 1. The facility staff administered the intravenous antibiotic prescribed for Resident #10 to Resident #15 2. The facility staff administered the intravenous antibiotic prescribed for Resident #15 to Resident #10. The findings include: 1. Resident #15 was admitted to the facility on 8/24/16 with diagnoses that included but were not limited to: sepsis (infection in the blood stream (1)), respiratory failure, diabetes, congestive heart failure, cirrhosis of the liver, and anemia. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 9/7/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring limited to extensive assistance for all of her activities of daily living except eating in which she only required supervision after set up assistance was provided.	F 333	F333 1. Residents #10 and #15 were discharged from the facility prior to survey. Nurse was disciplined per facility guidelines. 2. Residents receiving IV medications have the potential to be affected by this deficient practice. 3. The Staff Development Nurse or designee will educate licensed nurses on IV medication administration. 4. The Unit Managers or designee will conduct weekly audits of IV medication administration for four weeks, then randomly for 8 weeks to assure compliance. Audits will be reviewed and reported in QA for three months for review and revision as needed. 5. Date of compliance: December 15, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 28	F 333		

The "Facility Reported Incident" dated, 9/2/16, documented, "We are reporting a medication error which occurred yesterday. There were no apparent adverse effects from this error. The families and physician were aware of these errors. The patients were monitored for any adverse reactions by our staff and their attending physicians. The nurse making the error was counseled and received additional medication delivery training and monitoring. Resident (name of Resident #15) received Cefazolin (3) 1 gm (gram) IV (intravenous) times one dose instead of the prescribed Ampicillin (antibiotic used to treat infection (3)) 2 gm IV and Resident (name of Resident #10) received Ampicillin (2) 2 gm IV instead of Cefazolin 1 gm."

The physician order dated, 8/24/16, documented, "Ampicillin Sodium Solution (an antibiotic used to treat infections) (2) 2 GM (grams); Use 2 gram intravenously every 6 hours for infection for 10 days."

The resident's allergies documented in part, "Cephalexin (Keflex) (a Cephalosporin antibiotic used to treat infections) (3)

The physician progress note dated, 9/1/16, documented, "Chief Complaint: F/U (follow up) Medical Error - wrong IV (intravenous) antibiotic give for one dose. Resident has ordered and is receiving Ampicillin 2 Gram IV every 6 hours for enterococcus sepsis. Another Resident's IV antibiotic was hung instead in error X (times) 1 dose so that this resident received Cefazolin (a cephalosporin antibiotic used to treat infection (4))* 1 Gm (gram) IV x 1 dose. It is record in EHR (electronic health record) that this resident is "Allergic" to Cephalexin. When questioned,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 29	F 333		

resident says cephalexin causes nausea. C/O (complained of) nausea this am (morning) prior to this notification. Assessment and Plans: 1. Wrong medication medical error: Received Cefazolin 1 gram IV X 1 dose instead of Ampicillin 2 gm IV. Sustained known adverse reaction of nausea with this medication - offered Zofran (used to treat nausea (5)). Monitor for S/sxs (signs and symptoms) of additional negative effect. Resume correct medication drug for full complement of administration ordered." The physician who wrote this note was no longer employed at the facility and was unavailable for interview.

*Cefazolin: CONTRAINDICATIONS: CEFAZOLIN FOR INJECTION IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS (4)
The clinical record did not reveal any documentation of the error by the nurse that hung the incorrect antibiotic. (LPN [licensed practical nurse] # 3)

An interview was conducted with LPN #3 on 11/9/16 at 11:58 a.m. When asked how the wrong IV bag got hung for (Resident #15) LPN #3 stated, "I hung both resident's antibiotics. I was at the desk charting when the daughter of Resident #10 came to me and asked who (name of Resident #15) was. I asked her why she was asking that and the daughter told me that that's who's IV was hanging in her mother (Resident #10). I went to the unit manager and was told to get (name of nurse practitioner). (Name of nurse practitioner) and (name of registered nurse #1, the former assistant director of nursing) went in and assessed the resident. When asked how she hung the antibiotics, LPN #3 stated, "I brought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 30	F 333		

both bags out of the refrigerator to warm up a bit. I hung it up as usual. I didn't know I had done anything wrong until (Resident #10)'s daughter came to me. When asked if she followed the rights of medication administration, LPN #3 stated, "I thought I did." When asked if she was aware of Resident #15's allergies, LPN #3 stated, "Her son was here and (Name of nurse practitioner) spoke to son and they looked up her allergies."

An interview was conducted administrative staff member (ASM) #4, the nurse practitioner; on 11/9/16 at 12:15 p.m. ASM #4 was asked about the events that occurred on 9/1/16 with Resident #15 receiving the wrong IV medication. ASM #4 stated, "The attending physician and I went in to see the resident. The son was there and everything was explained to them. The son knew his mother's allergies. We discovered that is wasn't a true allergy but she experiences nausea when she takes that medication. She had complained of nausea and was given a dose of Zofran after the antibiotic error was found. (Name of attending physician) and I were not very concerned about it."

An interview was conducted with ASM #2, the director of nursing, on 11/9/16 at 1:38 p.m. When asked her knowledge of the incident above, ASM #2 stated, "I was informed by the unit manager of the mix up with the IVs. I was told that (ASM #4) was on the way to evaluate the residents involved. It was a serious medication error. The nurse involved was removed from the medication cart and could not return to the medication cart until she had completed in-service training with staff development and staff development did a medication observation of (LPN #3)." When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 31	F 333		

asked if the facility put a plan of action into place after the incident, ASM #2 stated, "We didn't put a plan of correction in to place as we felt it was an isolated incident. We did do an in-service for the nurses regarding medication administration on 9/2/16." When asked how medication errors are monitored, ASM #2 stated, "I report to the corporate nurse each week on any medication errors." When asked how many medication errors has the facility had since 9/1/16, ASM #2 stated, "I believe one but will get back with you."

ASM #2 returned to this surveyor on 11/10/16 at 8:10 a.m. She stated that they have had one medication error since 9/1/16 and presented a list of nurses who were in-serviced on 9/2/16. Approximately 80 % of the nurses employed at the facility were trained.

The facility policy, Medication Administration - General Guidelines" documented in part, "4. FIVE RIGHTS - Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of the 5 rights is recommended at three steps in the process of preparation of a medication for administration: 1. when the medication is selected. 2. When the dose is removed from the container, and finally, 3. Just after the dose is prepared and the medication put away."

The facility policy, "Legal Aspects of Infusion Therapy for Nurses" documented in part, "Nursing Responsibilities in Infusion Therapy: 4. Understanding the nature of the specific therapy being administered, including reason for the therapy, risks and potential complications and type and duration of therapy. 5. Know the 'Five Rights of Medication Administration' (right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 32	F 333		

medicine, right resident, right dose, right route and right time)."

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg. 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation. " Under the subheading Right Route (on pg. 708)"...When administering injections, precautions are necessary to ensure the nurse gives the medications correctly ..."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m.

Resident #10 was admitted to the facility on 8/13/16 with diagnoses that included but were not limited to: heart failure, endocarditis (an inflammation of the membrane lining the inside of the heart and the heart valves, caused by bacterial infection (6), repeated falls, high blood pressure and muscle weakness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 33 The most recent MDS (minimum data set) assessment, a 9/10/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non - Medical Reader, 5th edition, Rothenberg and Chapman; page 527. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000105/ (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009528/?report=details (4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=618b6e70-8562-45b7-8742-9bd4855e3ffb (5) This information was obtained from the following website: <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011501/?report=details> 2. The facility staff administered the intravenous antibiotic prescribed for Resident #15 to Resident #10.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 34	F 333		

Resident #10 was admitted to the facility on 8/13/16 with diagnoses that included but were not limited to: heart failure, endocarditis (an inflammation of the membrane lining the inside of the heart and the heart valves, caused by bacterial infection (6)), repeated falls, high blood pressure and muscle weakness.

The most recent MDS (minimum data set) assessment, a 9/10/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living.

The "Facility Reported Incident" dated, 9/2/16, documented, "We are reporting a medication error which occurred yesterday. There were no apparent adverse effects from this error. The families and physician were aware of these errors. The patients were monitored for any adverse reactions by our staff and their attending physicians. The nurse making the error was counseled and received additional medication delivery training and monitoring. Resident (name of Resident #15) received Cefazolin 1 gm IV times one dose instead of the prescribed Ampicillin 2 gm IV and Resident (name of Resident #10) received Ampicillin 2 gm IV instead of Cefazolin 1 gm."

The physician order dated, 8/13/16, documented, "Cefazolin (an antibiotic used to treat infections (1)) Sodium Solution Reconstituted 1 GM (gram): Use 1 gram intravenously (via a vein) every 12 hours for sepsis for 48 administrations for 24 days."

The "Physician Progress Note" dated 9/1/16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 35	F 333		

documented in part, "Chief Complaint: Asked to eval (evaluate) due to receiving the incorrect IV (intravenous) ABT (antibiotic) this am (morning). Pt is currently being tx (treated) with IV Cefazolin for endocarditis until 9/6/16. Pt (patient) received 2 gm of Ampicillin (an antibiotic used to treat infections (2)) IV today by mistake at 9 am (9:00 a.m.) Pt was seen immediately afterwards and has not had any S/S (signs and symptoms) of reaction to the medication. Key findings: No throat or tongue swelling. Assessment and Plans: Endocarditis acute/stable, no S/S of adverse reaction from being given ampicillin, scheduled ancef (Cefazolin) within time frame. Spoke with daughter about med (medication) error and informed her that I don't expect any negative adverse effects from pt receiving Ampicillin. Told to notify us if she or the private sitter noticed anything different with her. MD (medical doctor) will see later today as well as tomorrow."

The nurse's note dated, 9/1/16 at 6:53 p.m. documented in part, "Occurrence Details: Resident had received the wrong medication on 7-3 shift." There was no further documentation of the "Occurrence" in the clinical record.

An interview was conducted with LPN #3 on 11/9/16 at 11:58 a.m.. When asked how the wrong IV bag got hung for (Resident #10) LPN #3 stated, "I hung both residents' antibiotics. I was at the desk charting when the daughter of Resident #10 came to me and asked who (name of Resident #15) was. I asked her why she was asking that and the daughter told me that that's who's IV was hanging in her mother (Resident #10). I went to the unit manager and was told to get (name of nurse practitioner). (Name of nurse practitioner) and (name of registered nurse #1),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 36	F 333		

the former assistant director of nursing) went in and assessed the resident. When asked how she hung the antibiotics, LPN #3 stated, "I brought both bags out of the refrigerator to warm up a bit. I hung it up as usual. I didn't know I had done anything wrong until (Resident #10)'s daughter came to me." When asked how the wrong antibiotic got hung on Resident #10, LPN #3 stated, "I don't know. It was an honest mistake." When asked if she followed the rights of medication administration, LPN #3 stated, "I thought I did."

An interview was conducted with ASM #2, the director of nursing, on 11/9/16 at 1:38 p.m. When asked her knowledge of the incident above, ASM #2 stated, "I was informed by the unit manager of the mix up with the IVs. I was told that (ASM #4) was on the way to evaluate the residents involved. It was a serious medication error. The nurse involved was removed from the medication cart and could not return to the medication cart until she had completed in-service training with staff development and staff development did a medication observation of (LPN #3)." When asked if the facility put a plan of action into place after the incident, ASM #2 stated, "We didn't put a plan of correction in to place as we felt it was an isolated incident. We did do an in-service for the nurse's regarding medication administration on 9/2/16." When asked how medication errors are monitored, ASM #2 stated, "I report to the corporate nurse each week on any medication errors." When asked how many medication errors has the facility had since 9/1/16, ASM #2 stated, "I believe one but will get back with you."

ASM #2 returned to this surveyor on 11/10/16 at 8:10 a.m. She stated that they have had one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 37 medication error since 9/1/16 and presented a list of nurses who were in-serviced on 9/2/16. Approximately 80 % of the nurses employed at the facility were trained. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=618b6e70-8562-45b7-8742-9bd4855e3ffb (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0000105/ (6) Barron's Dictionary of Medical Terms for the Non - Medical Reader, 5th edition, Rothenberg and Chapman; page 192.	F 333		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.60(a),(b) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 38 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure medications were available for administration for one of 15 residents in the survey sample, Resident #5. The facility staff failed to ensure Livalo and Ranolazine were available for administration to Resident #5 as ordered by the physician. The findings include: Resident #5 was admitted to the facility on 11/7/16 with diagnoses that included but were not limited to: high blood pressure, elevated cholesterol levels in the blood, muscle weakness, stroke, fracture of lower leg, diabetes and history of breast cancer. There was no complete MDS (minimum data set) assessment as the resident was just admitted on the day prior to the start of the survey. The	F 425	F tag 425 Pharmacy Services 1. The medications for Resident #5 were received. 2. Residents receiving medications have the potential to be affected by this deficient practice. 3. The Staff Development Coordinator or designee will educate nurses on the Pharmacy Procedures, including ordering of medications, delivery times and deadlines, accessing the controlled drug stat box, and the content of the stat (first dose) boxes. Nurses will be instructed to notify the pharmacy of all new orders and follow up to assure timely delivery. 4. The Unit Managers or designee will audit new orders daily five times weekly for twelve weeks to assure that medications are ordered and received timely. Results of audits will be presented to the QA committee for review and revision monthly for three months for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 39 nursing admission assessment, dated, 11/7/16 at 4:10 p.m. documented the resident was alert and oriented to person and place, but not time. The resident was documented as appearing anxious. A brace was noted on the right leg. The physician orders dated, 11/7/16, documented, "Livalo Tablet (used to treat high cholesterol (1)) 1 MG (milligram); Give 1 tablet by mouth at bedtime for high cholesterol. Ranolazine ER (extended release) Tablet (used to treat angina - chest pain (2)) 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health." The MAR (medication administration record) for November 2016 documented, "Livalo Tablet 1 MG; give 1 tablet by mouth at bedtime for high cholesterol. The 11/7/16 dose was documented with a "19." A "19" code indicated, "See nurse's note." The nurse's note dated, 11/7/16 at 9:56 p.m. documented, "Livalo - Pending deliver (sic) from Rx (pharmacy)." This note was written by LPN (licensed practical nurse) #7. The November 2016 MAR (medication administration record) documented, "Ranolazine ER Tablet 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health." The dose for 9:00 p.m. on 11/7/16 was documented as having been given. The manifest from the pharmacy dated, 11/8/16 at 2:11 a.m. documented Resident #5's medications were delivered at 2:11 a.m. on 11/8/16. Review of the STAT (Immediate - emergency	F 425	review and revision as needed. 5. Date of completion: December 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 40	F 425		

box) failed to evidence the Livalo or Ranolazine ER in the box.

An interview was conducted with LPN (licensed practical nurse) #6 on 11/9/16 at 10:42 a.m., regarding the process staff follows when a medication is not available on the medication cart at the prescribed time of administration. LPN #6 stated, "First you check the STAT box and if it's not a medication that is in there, you call the pharmacy and find out what time it will be delivered. You have to notify the doctor and RP (responsible party) when a medication is not available to administer. The doctor may give you an order to hold that one dose."

An interview was conducted with LPN #7 on 11/9/16 at 2:35 p.m., regarding the process staff follows when a medication is not available for administration at the prescribed time. LPN #7 stated, "First you call the pharmacy and find out where it (the medication) is. You can pull it from the STAT box if it's available in the box." LPN #7 was asked if staff call the pharmacy at 9:00 p.m. at night. LPN #7 stated, "No, you can call the doctor to get a one-time order to hold the medication." LPN #7 was asked how she administered the Ranolazine to Resident #5 on 11/7/16 at 9:00 p.m., as Resident #5's medications were not delivered to the facility until 2:11 a.m. on 11/8/16 and the medication was not in the STAT box, yet she had documented the medication as having been administered, LPN #7 stated, "That's a documentation issue, I did not give it." When asked if she called anyone, LPN #7 stated, "No, I didn't."

The facility policy, "Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 41 Shortages/Unavailable Medications" documented in part, 3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply (STAT box). 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2. Use of an emergency (back up) Third Party Pharmacy. 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain orders or directions." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011950/?report=details	F 425		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an	F 441		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 42 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 441	F441 Infection Control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 43 policy review and clinical record review, it was determined that the facility staff failed to maintain infection control practices during wound care for two residents out of 15 residents in the survey sample, Resident #2 and Resident #7. 1. The facility staff failed to disinfect the skin cleanser bottle prior to returning it to the wound care cart for Resident #2. 2. The facility staff failed to disinfect the skin cleanser bottle prior to returning it to the wound care cart for Resident #7. The findings include: 1. Resident #2 was admitted to the facility on 1/1/16 and readmitted on 7/16/16 with diagnoses that included but were not limited to: high blood pressure, depression, an irregular heartbeat, pressure ulcer and urinary tract infection. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/21/16 coded the resident as having scored a 12 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as having an unstageable pressure ulcer on the sacrum. An observation was made on 11/9/16 at 10:27 a.m. with LPN (licensed practical nurse) #10, the wound care nurse. LPN #10 gathered her supplies and brought a bottle of skin cleanser into the room. LPN #10 placed the skin cleanser bottle on the barrier cover on the resident's overbed table. When the wound care was	F 441	1. The wound cleanser bottles for residents #2 and #7 were replaced. 2. Residents receiving wound care have the potential to be affected by this deficient practice. 3. The Staff Development Coordinator or designee will educate licensed nurses on proper technique for wound care. 4. The staff Development Coordinator or designee will perform random observations of wound care daily five times weekly for four weeks, then randomly for eight weeks. Results of audits will be taken to the QA committee for review and revision for three months for review and revision as needed. 5. Date of compliance: December 15, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 44	F 441		

completed, LPN #10 took the wound cleanser bottle off the barrier and set in on the unprotected overbed table. LPN #10 disposed of the barrier and returned the cleanser to the wound care cart without disinfecting the bottle.

An interview was conducted on 11/9/16 at 1:50 p.m. with LPN #10. When asked the process staff follows when they take a skin cleanser bottle into a resident's room and then return it to the wound care cart, LPN #10 stated, "I would wipe the bottle down with bleach wipes." When the wound care observation was shared with LPN #10 she stated, "I didn't do it with you but I did wipe it down later." When asked why staff wipe down the bottle, LPN #10 stated, "It's cross contamination."

On 11/9/16 at 5:35 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Infection Control" documented, "PURPOSE: To protect residents and staff by preventing the spread of infection. PROCEDURE: e. Resident care equipment and work areas shall be cleaned according to manufacturer's specifications..."

No further information was provided prior to exit.

2. Resident # 7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited to: diabetes mellitus (1), depression, hypertension (2), pain, vascular dementia (3), and gastroesophageal reflux disease (4).

Resident # 7's most recent comprehensive MDS (minimum dada set) a significant change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 45	F 441		

assessment with an ARD (assessment reference date) of 7/20/16 coded the resident as scoring a 6 (six) on the brief interview for mental status (BIMS) of a score of 0 - 15, 6 (six) being severely impaired cognition for daily decision making. Resident # 7 was coded as requiring extensive assistance of one staff member for activities of daily living. Section M "Skin Condition" coded Resident # 7 with a pressure ulcer.

An observation of wound care for Resident #7 was observed on 11/9/16 at 8:50 a.m. with LPN #10, the wound care nurse. LPN #10 brought in the wound dressing supplies which included a bottle of skin cleanser. LPN #10 briefly placed the bottle on the resident's pillow and then moved the bottle to a pillow on the chair next to the resident's bed. When the wound care was completed LPN #10 took the bottle of skin cleanser and returned it to the wound care cart without disinfecting it.

An interview was conducted on 11/9/16 at 1:50 p.m. with LPN #10. When asked the process staff follows when they take a skin cleanser bottle into a resident's room and then return it to the wound care cart, LPN #10 stated, "I would wipe the bottle down with bleach wipes." When the wound care observation was shared with LPN #10 she stated, "I didn't do it with you but I did wipe it down later." When asked why staff wipe down the bottle, LPN #10 stated, "It's cross contamination."

On 11/9/16 at 5:35 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 46 Reference: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period. This information was obtained from the website: https://medlineplus.gov/ency/article/000746.htm. (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.	F 441		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.75(l)(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 47 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 15 residents in the survey sample, Resident #5. Resident #5's clinical record inaccurately documented the administration of a medication on 11/7/16 at 9:00 p.m., when the medication was not administered to Resident #5. The findings include: Resident #5 was admitted to the facility on 11/7/16 with diagnoses that included but were not limited to: high blood pressure, elevated cholesterol levels in the blood, muscle weakness, stroke, fracture of lower leg, diabetes and history of breast cancer. There was no complete MDS (minimum data set) assessment as the resident was just admitted on the day prior to the start of the survey. The nursing admission assessment, dated, 11/7/16 at 4:10 p.m. documented the resident was alert and oriented to person and place, but not time. The resident was documented as appearing anxious. A brace was noted on the right leg.	F 514	F514 Accurate Medical Record 1. Current medications for Resident #5 are on hand. The nurse responsible for the inaccurate charting of Resident #5's medication administration was counseled and disciplined. 2. Residents with medication orders have the potential to be affected by this deficient practice. 3. Licensed nursing staff were educated by the Staff Development Coordinator or designee of the importance of accurate and timely documentation. 4. Unit Managers or designees will audit the Medication Administration Records five times weekly for four weeks, then randomly for eight weeks to assure that documentation is complete and accurate. Results of audits will be taken to the QA for review and revision as needed monthly for three months for review and revision as needed. 5. Date of compliance: December 15, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 48	F 514		

The physician orders dated, 11/7/16, documented, " Ranolazine ER (extended release) Tablet (used to treat angina - chest pain (2)) 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health."

The November 2016 MAR (medication administration record) documented, "Ranolazine ER Tablet 12 hour 500 MG; Give 1 tablet by mouth two times a day for heart health." The dose for 9:00 p.m. on 11/7/16 was documented as having been given.

The manifest from the pharmacy dated, 11/8/16 at 2:11 a.m. documented Resident #5's medications were delivered at 2:11 a.m. on 11/8/16.

Review of the STAT (Immediate - emergency box) failed to evidence the Ranolazine ER in the box.

An interview was conducted with LPN #7 on 11/9/16 at 2:35 p.m., regarding the process staff follows when a medication is not available for administration at the prescribed time. LPN #7 stated, "First you call the pharmacy and find out where it (the medication) is. You can pull it from the STAT box if it's available in the box." LPN #7 was asked if staff call the pharmacy at 9:00 p.m. at night. LPN #7 stated, "No, you can call the doctor to get a one-time order to hold the medication." LPN #7 was asked how she administered the Ranolazine to Resident #5 on 11/7/16 at 9:00 p.m., as Resident #5's medications were not delivered to the facility until 2:11 a.m. on 11/8/16 and the medication was not in the STAT box, yet she had documented the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 49	F 514		

medication as having been administered, LPN #7 stated, "That's a documentation issue, I did not give it." When asked if she called anyone, LPN #7 stated, "No, I didn't."

Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 reads: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #1, the assistant director of nursing, and ASM #3, the regional nurse consultant, were made aware of the above findings on 11/9/16 at 5:25 p.m.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011950/?report=details